

CORRESPONDENCE

set a precedent. Two dictums are relevant here. First, do not allow a fetal disaster deteriorate into a maternal disaster. Second, it is always preferable to give a dead baby to a living mother than to give a dead mother to a living husband.

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(Accepted for publication September 10, 1997.)

Anesthesiology
1998; 88:276
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To the Editor:—Although I read with interest the case report by Schaut *et al.*, their report raises the concern that inhalation induction of anesthesia with sevoflurane for emergency cesarean section should be considered a "suitable alternative" when intravenous access is not available.¹ Whereas the authors endeavor to justify their decision, they minimize the significance of the maternal risk involved. The authors correctly state that the parturient undergoing emergency cesarean section is considered to have a full stomach and acknowledge the risk for aspiration. However, they do not clarify that the parturient has decreased lower esophageal sphincter tone and increased intragastric pressure and that the stimulus of uterine traction during cesarean section delivery places the parturient at extremely high risk of regurgitation. Additionally, laryngeal reflexes are absent during the stage of general anesthesia described in this case, and spontaneous ventilation with an unprotected airway makes this patient particularly susceptible to aspiration.

The authors also contend that infiltration with local anesthetics may take several minutes to accomplish and that the technique is no longer taught in most obstetric residencies.² However, this technique is described in major obstetrics textbooks.^{3,4} Additionally, an informal survey of staff obstetricians practicing at our institution revealed that all are familiar with local anesthetic infiltration for cesarean section, and most state that they would use this technique in an obstetrical emergency. Although the authors described a case with good maternal and fetal outcome, the risk involved and the potential for an unfavorable outcome advocate against suggesting inhalation induc-

tion with sevoflurane as a "suitable alternative" for emergency cesarean section.

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(Accepted for publication September 10, 1997.)

Anesthesiology
1998; 88:276-7
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Lippincott-Raven Publishers

To the Editor:—We read the recent case report by Schaut *et al.* (*ANESTHESIOLOGY* 1997; 86:1392-4) describing a sevoflurane induction for emergency cesarean delivery. We cannot agree that the approach described is a reasonable alternative. The choice of an inhalation induction is not new to obstetric management and may be warranted under some extremely rare situations; however, to proceed without first establishing intravenous access seems to be an unnecessary risk. Bonica's classic text describes mask inhalation

induction with cyclopropane, and it is stated that "... when cesarean section is planned, an endotracheal tube is introduced with the aid of succinylcholine".¹ Anesthesiologists are experts at establishing vascular access. An internal jugular or subclavian catheter can be rapidly inserted, and a proper induction conducted. In addition, the induction of general anesthesia, under any circumstance, should not be undertaken without the application of routine monitors. If the obstetrician is so desperately inclined to begin the operation,